APPENDIX B
Local Hospital Statistics

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
1. Charity	22,028	16,114	1,125	832
2. Southern Baptist	8,889	3,728	603	474
3. Ochsner Foundation	8,236	3,557	531	413
4. EAST JEFFERSON GENERAL	8,211	6,735	440	353
5. Touro Infirmary	8,132	6,822	509	395
6. Pendleton Memorial Methodist	6,328	3,834	318	211
7. Hotel Dieu	5,253	3,903	323	254
8. Lakeside	4,915	3,719	209	141
9. Veterans Administration	4,162	2,564	467	397
10. Mercy	4,063	3,363	240	195
11. Tulane Medical Center	N/A	N/A	235	190
12. St. Charles General	2,696	2,055	168	139
13. Flint-Goodridge	1,745	1,689	113	N/A
14. St. Claude General	1,698	1,583	136	81
15. Eye & Ear Institute	1,606	1,011	71	N/A
16. Montelepre Memorial	958	828	64	49

Local Hospital Statistics (continued)

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
17. Children's	951	597	105	61
18. New Orleans Mental Health	488	363	237	165
19. Metairie	476	418	84	N/A
20. Coliseum House	156	99	168	140
21. River Oaks	93	44	85	69
22. US Public Health	N/A	N/A	N/A	N/A
SUBTOTAL	91,084	63,026	6,231	4,559
East Jefferson Percentage	9.0%	10.7%	7.1%	7.7%
"Top Four" Percentage	52.0%	53.3%	44.4%	46.4%
Herfindahl-Hirschman Index	1,096	1,137	[illegible]	872
Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)				
23. West Jefferson	9,160	7,846	403	332
24. JoEllen Smith	4,383	3,789	336	174
25. Slidell Memorial	3,745	69	182	N/A

Local Hospital Statistics (continued)

Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
26. Tammany	2,856	26	160	121
27. Chalmette	1,617	158	109	91
28. Southeast Louisiana	1,172	573	493	423
29. Highland Park	N/A	N/A	96	N/A
30. South Jefferson	704	604	75	23
31. St. Bernard	357	45	39	N/A
TOTAL	115,078	76,136	8,144	5,723
East Jefferson Percentage	7.1%	8.9%	5.4%	6.2%
"Top Four" Percentage	42.0%	49.3%	34.0%	37.8%
Herfindahl-Hirschman Index	785	911	564	658

Note: N/A = Not Available.

(1) Source: Ex. D-5 (New Orleans area hospital identification and locations).

(2) Admission data are for the period November 1, 1978 to April 30, 1979. Source: Ex. D-7.

(3) Source: American Hospital Assoc., *American Hospital Association Guide to the Health Care Field*, pp. A-91 to A-96 (1982).

NO. 82-1031

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In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD,

PETITIONERS

V.

DR. EDWIN G. HYDE,

RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether a public hospital possessing market power creates an illegal tying arrangement when it compels users of the hospital's surgical facilities to purchase anesthesia services from a professional corporation of anesthesiologists with which the hospital has a contractual agreement to share fees.

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BRIEF FOR THE RESPONDENT

STATEMENT OF THE CASE

This action was brought by the respondent, Dr. Edwin G. Hyde ("Dr. Hyde") for declaratory and injunctive relief concerning his exclusion from the medical staff at East Jefferson General Hospital ("the Hospital"),[1] a public facility located in Jefferson Parish, Louisiana. Dr. Hyde's application for appointment to the medical staff

[1] For convenience, this brief sometimes also will refer to the petitioners, Jefferson Parish Hospital District No. 2 ("the District") and East Jefferson Hospital Board ("the Board") collectively as "the Hospital."

was denied solely because the Hospital had entered into an "exclusive" contract with another group of anesthesiologists named Roux and Associates. (Pl. Ex. 6; R. 26-27, 94).[2] Dr. Hyde asked the district court to declare that his exclusion from the medical staff was illegal for several reasons,[3] including that it violated Section 1 of the Sherman Act. Dr. Hyde contended that the Hospital's actions violated the Sherman Act either under the Rule of Reason (A., 8-9), or as a per se illegal tying arrangement in that users of the Hospital's surgical facilities (the tying product) also were compelled to purchase anesthesia services (the tied product) from Roux & Associates. (A., 8).

Following a trial, the district court entered Findings of Fact and Conclusions of Law denying all of Dr. Hyde's claims. *Hyde v. Jefferson Parish Hospital District No. 2*, 513 F.Supp. 532 (E.D. La. 1981). The court of appeals reversed, holding that the Hospital's exclusive contract with Roux & Associates created a tying arrangement that was illegal per se. *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982).[4]

---

[2] The trial record contains three volumes; however, only two of the volumes are numbered. This brief will use the following trial record references:

Testimony of Mose Ellis on May 15, 1980—"R."

Other testimony on May 15, 1980—"R., Vol. I."

All testimony on May 16, 1980—"R., Vol. II."

[3] Only Dr. Hyde's Sherman Act claim is before this Court.

[4] The court of appeals also held that Dr. Hyde was entitled to an injunction requiring the Board to appoint him to the Hospital's medical staff. 686 F.2d at 294. As the Hospital did not seek a stay from the court of appeals' mandate, the district court issued the injunction on April 26, 1983. The Board appointed Dr. Hyde to the Hospital's medical staff on May 24, 1983.

1. *The Hospital.*

The Hospital is owned and operated by the District, which was created pursuant to Louisiana law by Jefferson Parish, Louisiana as a political subdivision of the state. (Pl. Ex. 1; R., 7, 94). The geographic boundaries of the District encompass only that part of Jefferson Parish located on the East Bank of the Mississippi River. (*Id.*). The portion of Jefferson Parish located on the West Bank of the Mississippi River is served by a separate public hospital, known as West Jefferson General Hospital. (*Id.*). According to its enabling legislation, the purpose of the District is to own and operate hospitals within the District and to provide hospital and other health services to the residents of the District. La. R.S. 46:1052.

As the Hospital is the only public hospital located on the East Bank of Jefferson Parish (R., 7), it draws patients primarily from that area. Evidence at trial showed that over seventy percent of the patients admitted to the Hospital live within the geographic boundaries of the District. (A., 50). The same evidence showed that the Hospital captures approximately thirty percent of all residents of the District who are admitted to any hospital. (A., 49).

The Board was appointed by the Jefferson Parish Council pursuant to state law to govern the operation of the District. (R., 8). The board is directed by statute "[t]o represent the public interest in providing hospital and medical care in the district." La. R.S. 46:1055. One of the Board's specific functions is to make appointments to the Hospital's medical staff "upon the recommendations of the physicians who are authorized to practice within the hospital." La. R.S. 46:1058.

2. *The Hospital's medical staff.*

The Hospital's medical staff is organized as an entity separate and apart from the Hospital itself. (R., 9-10). The medical staff has enacted and is governed by its own by-laws, and it elects its own offices and committees. (R., 10).

The medical staff by-laws (Def. Ex. 2; R., Vol. I, 55, 56) place primary responsibility on the medical staff for the quality of patient care. Membership on the medical staff is limited to physicians "who are located closely enough to the hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active medical staff: including emergency service care and consultation arrangements." (*Id.* at 4). Initial appointments to the medical staff are provisional (*Id.* at 6) and can be made by the Board only upon recommendation of the existing staff. (*Id.* at 3). Before it makes any recommendation regarding an applicant, the medical staff, through a credentials committee, must examine the applicant's "character, professional competence, qualifications and ethical standing" and "determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications...." (*Id.* at 7). Each staff member is subject to annual review and reappointment (*Id.* at 10-11). The medical staff may take corrective action at any time when "the activities of professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the medical staff as to be disruptive to the operations of the hospital." (*Id.* at 14).

3. *Dr. Hyde's application.*

Dr. Hyde submitted an application for appointment to the Hospital's medical staff on July 14, 1977 (A., 29-33). Pursuant to the medical staff by-laws, the application was reviewed by the medical staff credentials committee, which recommended Dr. Hyde's appointment. The medical staff executive committee also reviewed the application and submitted a recommendation to the Board that the application be approved. (R., 14-17).

In spite of the medical staff's favorable recommendations, the Board voted on October 18, 1977 to deny Dr. Hyde's application. (R., 21-23). Dr. Hyde was notified of the Board's decision by letter from the Hospital's executive director stating that the application had been denied "in view of the exclusive nature of the contract between the hospital and Roux & Associates and due to the fact that we have no openings in the Department of Anesthesia." (Pl. Ex. 6; R., 26-27, 94). The Hospital's executive director, Mose Ellis, explained at trial that his statement that there were "no openings in the Department of Anesthesia" meant only that Roux & Associates did not intend to employ Dr. Hyde. (R., 27-28).

4. *The exclusive contract.*

Before the Hospital opened its doors in 1971, the Board reached a decision to enter into an exclusive contract with one anesthesiologist. According to the two Board members who testified at trial, the members of the Board believed that an exclusive contract was necessary in order to attract an anesthesiologist to a new hospital with no track record. Dr. John C. Rourke described the situation in this way:

> First, we have to cast ourselves back into the situation we're in back in 1970. We had an empty building sticking up there in the sky in the middle of a drain [sic] swamp, which had never been a hospital before, and we had a new, untried, untested venture. And we had to build from scratch. We were not overwhelmed with eager people looking for the various jobs in the hospital base specially [sic].
>
> I know that this trial is about anesthesiologists, but in my own recollection of the period, we had four separate jobs to fill. Anesthesiology was one of them. And in two of the areas, we had to really persuade people, Come on in and give us a try. It was an unopened book. We had no fiscal experience. They had to cast in their lot with us and take the chance that we would be a success. In anesthesia—Well, we felt that each department of the four departments only required one man to get it started. And even some of those men applicants were unsure whether they would be able to make a living at it. It was an untested venture. So, we were looking for one good man in each area to come in to cast—tie his future to ours, work with us and build a department.

(R., Vol. II, 149-50). Nickolas Gagliano, a member of the initial Board and chairman of the Board at the time of trial, expressed similar sentiments. Mr. Gagliano said: "I doubt very much if Dr. Roux or anybody else, Dr. Hyde included would have come to our hospital if we didn't give them what you call a monopoly." (R., Vol. II, 195).

The initial contract between the Hospital and Roux & Associates (A., 18-22), executed in February, 1971, provided that "[t]he Hospital shall restrict the use of its anesthesia department to Roux & Associates and no other

persons, parties or entities shall perform such services within the Hospital for the terms of this Contract." (A., 19). When a second contract (A., 23-28) was executed in January, 1976, the provision was deleted at the request of Roux & Associates' president, Dr. Kermit Roux. At trial, Dr. Roux explained the reason for his request.

> Q. The Judge asked you if in fact when the 1976 contract was negotiated and executed, you asked that language calling for the exclusion of other anesthesiologists be deleted from the contract. .
>
> A. Yes, sir.
>
> Q. So that it would no longer be a part of the contract?
>
> A. Yes, sir. The reason we did that, there were a number of reasons. There was this other group that had requested to come practice there and led us to believe that some physicians preferred them to give their anesthetics. And if that were true, then I think that they should be allowed to practice.
>
> The other reason is pretty much what you have alluded to, I didn't want to be there on the basis of hiding behind a contract. If I couldn't provide the service as best I could, then someone else ought to have a shot at it.
>
> And I have been told by people a number of times that, you're hiding behind the contract because it gives you "exclusive privileges" and doesn't let anyone else come. And I don't believe that that's the way medicine should be practiced. It should be practiced on the basis of the person whom the physician or the patient feels can do the best job, should be their physician.

> So, we finally got them to delete that part of the contract.

(R., Vol. I, 7-8).

Although Dr. Roux obtained a change in the language of the 1976 contract because he felt it was wrong to exclude another qualified physician from the medical staff, the Hospital interpeted the 1976 contract as continuing to require the exclusion of all other anesthesiologists. Mr. Ellis testified that another provision, which remained in the 1976 contract, had the same effect as the provision deleted. (R., 37-38).

Both the 1971 contract and the 1976 contract prohibited Roux & Associates from providing anesthesia services at other hospitals. (A., 19, 25; R., 38-39).[5] However, during 1977, at least two of the three anesthesiologists then employed by Roux & Associates routinely traveled to Lakeside Hospital, located nearby, to handle cases. (R., Vol. I, 23-24). Mr. Ellis acknowledged that he had been informed of this apparent contractual breach by Roux & Associates, but testified that he did "nothing about it." (R., 40-41). According to Mr. Gagliano, it took a special ad hoc committee of the Board to persuade Roux & Associates to confine its practice to the Hospital (R., Vol. II, 176-79).

The anesthesia charge billed to each patient at the Hospital was determined by Roux & Associates according to the length and complexity of the procedure performed.[6]

---

[5] The 1976 contract did permit Roux & Associates to engage in "teaching, research and limited consultative activities...other than on the Hospital premises." (A., 25). However, Mr. Ellis testified that this contract provision "[w]ould not allow them to do very much." (R., 39).

[6] Although the 1976 contract provided that "the Hospital shall

The total charge billed to a patient included a "professional component," intended to cover the actual services of the anesthesiologist, and a "hospital component," intended to cover related services and supplies furnished by the Hospital. (R., 82-83; R., Vol. I, 26). The patient was charged separately by the Hospital for drugs and medicines used in connection with the anesthesia procedure. (A., 27; R., 83).[7]

The Hospital collected payment from each patient and, at the end of each month, it remitted to Roux & Associates fifty percent of all receipts, less an eight percent deduction for bad debts, charity and other write-offs. (A., 26-27; R., 84-85). The fifty percent share retained by the Hospital was a negotiated figure that was unrelated to the Hospital's actual costs. (R., 85-86). Thus, under the 1976 contract, both the Hospital and Roux & Associates received a fifty percent share of each patient's total anesthesia charge irrespective of the length and complexity of the procedure or of the nature of the professional and hospital services actually rendered.

The Hospital derived a substantial (and increasing) profit from its financial arrangement with Roux & Associates. (A., 51). The anesthesia fees retained by the Hospital substantially exceeded the costs it incurred in maintaining and operating the department of anesthesio-

---

(Footnote 6 continued)
establish the amounts to be charged to patients for services rendered in the Hospital's department of anesthesia" (A., 26), in practice the Hospital permitted Roux & Associates to determine the charge. Mr. Ellis testified: "The hospital personnel do not compute this charge. We allow the M.D. anesthesiologists to compute that charge that goes on the patient's bill." (R., 84).

[7] Although Roux & Associates now bills its patients directly for its services, the Hospital continues to bill for related services, supplies, drugs and medicines furnished by it.

logy. (*Id.*; R., 88-93).

5. *The relationship between anesthesiologists and nurse anesthetists.*

The Hospital's major expense in operating the department of anesthesiology was the compensation paid to the nurse anesthetists whom it employed to work with Roux & Associates.[8] Under the 1976 contract, the Hospital was required to employ all nurse anesthetists, but their selection was subject to the approval of Roux & Associates. (A., 24).[9]

At the time of trial, at least one nurse anesthetist was assigned to each of the Hospital's thirteen operating rooms and the four (three at the time of Dr. Hyde's application for admission to the staff) anesthesiologists employed by Roux & Associates traveled from room to room as they were called upon for supervision. (R., Vol. I, 29-31; R., Vol. II, 4-7). The anesthetic given to a patient normally was administered by a nurse anesthetist; an anesthesiologist remained with a patient only for the more complicated operations. (*Id.*) In routine cases, nurse anesthetists might in fact make the decision as to what anesthetic to administer and might administer an anesthetic without any direct supervision at all. (R., Vol. I, 75-78).

All of the anesthesiologists who testified at trial agreed that nurse anesthetists remain necessary in Loui-

[8] Roux & Associates now employs and compensates the nurse anesthetists directly.

[9] Dr. Hyde employs his own nurse anesthetists at Lakeside Hospital and he testified that, except for obstetric cases, he would continue to do so upon being admitted to the Hospital's medical staff. (R., Vol. II, 63, 78-79).

siana because there are not enough M.D. anesthesiologists available. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45).[10]

6. *The impact of exclusive contracts on patient care.*

All of the physicians who testified at trial agreed that a patient or surgeon should be free to choose an anesthesiologist based on an evaluation of his or her ability and competence. (R., Vol. I, 34-36, 64-65; R., Vol. II, 29, 157-58). Relying on its exclusive contract with Roux & Associates, the Hospital admittedly denied this freedom of choice to both patients and surgeons. (R., 72-73).

There also was undisputed testimony that the exclusion of competition in the practice of anesthesiology tends to reduce the incentive for medical improvement or innovation. Dr. John Adriani, an internationally recognized expert in the training of anesthesiologists and the practice of anesthesiology (A., 52-76), described how the absence of intrahospital competition among anesthesiologists can affect the quality of patient care delivered:

> Q. Doctor, in your opinion, does the closed staff arrangement have a general effect on the quality of care given the patient in a general sense?
>
> A. Yes. And I think having a closed staff creates a monopoly. And it wants [should be "thwarts"] competition among physicians.
>
> Q. You're saying then that the competition would improve or is beneficial to the delivery of patient care?

[10] At the time of trial, there were only about 156 anesthesiologists available to service the approximately 345 hospitals in the state. (R., Vol. I, 73).

> A. Yes, it is. A good example of that is at the Baptist Hospital. There was one group in there and a second group just formed in the last several years. And the original group wouldn't do certain procedures. For instance, they were not interested in doing the particular block that we call epidural block. This other group came in and started to do them, and so then the other group started doing them. So, as a result, the patients are getting better care and getting a wider variety of anesthesiology than they did originally.

(R., Vol. II, 30).

In addition to stifling medical innovation, the evidence indicated that exclusive contracts encourage hospitals, for financial reasons, to employ a greater number of nurse anesthetists to the exclusion of M.D. anesthesiologists. Nurse anesthetists are trained and utilized by anesthesiologists only because of the shortage of anesthesiologists. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45). A nurse anesthetist is not a physician and is trained to work only under the supervision of an anesthesiologist. (R., Vol. II, 22-23). Furthermore, there are practical limits to the number of nurse anesthetists that an anesthesiologist can supervise properly. (R., Vol. II, 31-32, 41). However, because hospitals realize a profit by hiring their own nurse anesthetists and splitting anesthesia fees with a small contract group of anesthesiologists (R., Vol. II, 36-38), they have an incentive to make the ratio of nurse anesthetists to anesthesiologists as large as possible (R., Vol. II 32-33).

7. *The impact of exclusive contracts on competition among anesthesiologists.*

An anesthesiologist normally is selected by the

surgeon rather than the patient based on a familiarity gained through a working relationship. (R., Vol. II, 26-27). However, a surgeon cannot develop a familiarity with an anesthesiologist unless there is an initial opportunity for them to work together (R., Vol. II, 27-28). The Hospital's exclusive contract with Roux & Associates precluded any surgeon using the Hospital's operating rooms from selecting and working with any anesthesiologist other than a member of Roux & Associates.

In some instances, patients do ask for a particular anesthesiologist. (R., Vol. I, 87-88; R., Vol. II, 28-29). Moreover, the nature of Dr. Hyde's practice makes it much more likely that patients will request his services. Approximately fifty percent of Dr. Hyde's work involves the subspeciality of obstetric anesthesia and, more particularly, the administration of epidural anesthetics. (R., Vol. II, 61-64, 72-73).[11] Due to the nature of his subspecialty, Dr. Hyde's relationship with his obstetric patients is more personal than the usual relationship between an anesthesiologist and a patient. (R., Vol. II, 73-74). As a result, it is not uncommon for an obstetric patient to request specifically that Dr. Hyde, or one of his associates, serve as her anesthesiologist. (R., Vol. II, 74). An obstetric patient at the Hospital, however, would have been refused if she had requested Dr. Hyde's services. (R., 72-73).

Exclusive contracts also tend to limit the total number of anesthesiologists available to serve patients in the market. Although there is an admitted shortage of anesthesiologists in the market area,[12] anesthesiologists

[11] Epidural anesthetics are administered by anesthesiologists rather than nurse anesthetists. (R., Vol. II, 64).

[12] This would be true regardless of the geographic market definition.

who do not have exclusive arrangements with hospitals are forced to look elsewhere for practice opportunities. (R., Vol. II, 30-31, 33, 92-95). In addition, medical students who wish to remain in the area to practice are discouraged from entering the specialty of anesthesiology because of the difficulty they will have in finding employment. (R., Vol. II, 31).

8. *The decisions of the lower courts.*

The district court found that the Hospital's exclusive contract with Roux & Associates created a tying arrangement in that surgical facilities and anesthesia services are separate products. 513 F.Supp. at 542. The court also found that the exclusive contract restrained competition among anesthesiologists. *Id.* at 541. However, the district court declined to hold the exclusive contract illegal per se for two reasons. First, the court opined "that the per se rules used in antitrust cases governing regular commercial activities should not be made automatically applicable to cases involving professional activities." *Id.* at 542. In support of this view, the court cited footnote 17 of *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).[13] *Id.* at 543. Second, the district court held that Dr. Hyde failed to show that the Hospital "dominated" the relevant geographic market for surgical facilities. 513 F.Supp. at 542-43.

The market which the district court concluded the Hospital did not dominate was defined by the court to include at least the East Bank of both Orleans and Jefferson

[13] The Hospital apparently no longer contends (as it did in the district court) that it should be exempted from the rules of per se illegality. See Brief for the Petitioners, 4 n. 3. Therefore, we will review here only the district court's second ground for holding that the exclusive contract was not per se illegal.

Parishes, Louisiana. *Id.* at 540. Although the court acknowledged that patients have a natural preference for hospitals near their homes,[14] it apparently did not consider this fact in determining the relevant geographic market.[15] The only evidence cited by the district court in support of its market definition was that "[s]eventy per cent (70%) of the patients living in East Bank Jefferson Parish go to hospitals other than East Jefferson." *Id.*

Having defined the market to include the East Bank of both Jefferson and Orleans Parishes, the district court concluded that a per se violation had not been proven because "[t]here was no evidence that East Jefferson was a dominant economic power in the market in which it competes." *Id.* at 541.

While the case was awaiting argument in the court of appeals, the Board declared the Hospital's department of anesthesiology to be "open" and moved to dismiss the appeal as moot.[16] Dr. Hyde opposed the motion and it was

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[14] The district court stated:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible.

513 F.Supp. at 543.

[15] The court stated that it did "not find this factor is proof that East Jefferson is a strong economic power in the market in which it competes." 513 F.Supp. at 543. Thus, the district court apparently considered the preference for nearby hospitals only as an indication of market power, not as an indication of the market itself.

[16] Although the Hospital now claims that the "opening" of the department of anesthesiology resulted merely from the expiration of the 1976 contract (Brief for the Petitioners, 6), in its motion to dismiss it represented that the "opening" resulted from a policy change on the

denied by the court of appeals. (A., 79). Although Dr. Hyde did not accept the Hospital's invitation (A., 77-78) to reapply for medical staff membership, he did obtain from the district court on April 26, 1983 an injunction ordering the Board to admit him to the medical staff without further delay.[17] On May 24, 1983, the Board complied with the district court's injunction by formally appointing Dr. Hyde to the Hospital's medical staff.

On the merits, the court of appeals reversed the decision of the district court. The court of appeals agreed with the district court that the exclusive contract created a tying arrangement,[18] but unlike the district court, the court of appeals held that the criteria for per se illegality were satisfied.

One difference between the decision of the district court and the decision of the court of appeals was the definition of the relevant geographic market. Whereas the district court had assumed without inquiry that the market for the provision of surgical facilities functioned in a

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(Footnote 16 continued)
part of the Board. (A., 77-78; see also the Memorandum in Support of Motion to Dismiss Appeal filed by the Hospital).

[17] The Hospital neither sought nor obtained a stay of the mandate of the court of appeals pending review by this Court.

[18] The court of appeals stated:

> The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately.

686 F.2d at 289.

completely competitive manner, the court of appeals recognized that the market is affected substantially by factors other than comparisons of quality and price. 686 F.2d at 290. Citing the prevalence of third-party payment of bills and the inability of patients to evaluate and compare the quality of medical care offered, the court of appeals reasoned that patients and surgeons are more likely to choose a hospital (particularly a public hospital) close to their homes and offices. *Id.* The court held that the district court's failure to consider its own findings regarding the preference for nearby hospitals led it to define the relevant geographic market too broadly. *Id.* at 290-91.[19]

Under a narrower definition of the relevant geographic market, the court of appeals easily found that the Hospital had sufficient market power to restrain competition in the market for the tied product. Relying on this Court's decision in *Northern Pacific Railway Company v. United States*, 356 U.S. 1 (1958), the court of appeals held that the district court had erred in requiring a showing that the Hospital "dominated" the market for the tying product. 686 F.2d at 289. The court of appeals concluded that a market share of thirty percent provided "sufficient market power in the tying market to coerce purchase of the tied product." *Id.* at 291.

The court of appeals also took into account the several anticompetitive effects resulting from the use of exclusive contracts. In addition to directly preventing any real competition among anesthesiologists, the court noted that the use of exclusive contracts also discourages entry

[19] As further support for its conclusion that the relevant geographic market was limited to the East Bank of Jefferson Parish, the court of appeals noted the geographic limits placed on the District and the Board by state law. 686 F.2d at 291.

of new competitors into the market and reduces the incentive for improving the quality of anesthesia care provided by those already in the market. *Id.* at 291-92.

In response to the Hospital's claim that its tying arrangement was justified by business considerations, the court of appeals pointed out that the exclusive contract was not necessary to achieve any of the Hospital's asserted goals. Thus, the court held that the Hospital's asserted business justifications could not insulate the exclusive contract from per se illegality. *Id.* at 292.

SUMMARY OF ARGUMENT

1. The Hospital's exclusive contract with Roux & Associates was not a benign arrangement that merely permitted the Hospital to operate more efficiently without causing any detriment to patients. In fact, the contract was harmful to patients in several ways. First, it deprived both patients and surgeons of the freedom of choosing their own anesthesiologist, a freedom protected both by antitrust law and by traditional health care standards. Second, the exclusive contract is likely to be detrimental to the quality of patient care by encouraging a greater use of less qualified nurse anesthetists to the exclusion of M.D. anesthesiologists, and by eliminating the incentive for innovation and technical improvement by the contract group. Third, the economics of the exclusive contract indicate that it must have resulted in higher costs to patients. In sum, it is fair to say that exclusive contracts cause harm to patients.

2. Exclusive contracts restrain competition among anesthesiologists both directly and indirectly. Directly, the contract results in the denial to all but the chosen contract

group of what every anesthesiologist must have in order to compete—staff privileges. The fact that Dr. Hyde had staff privileges at another hospital did not cure the harm. Due to the Hospital's status as the only large public hospital in the market, the physicians to whom the Hospital grants staff privileges are given a competitive advantage over those to whom it does not. The Hospital offers greater professional opportunity than does any other hospital in the same market. Indirectly, exclusive contracts restrain competition by creating artificial barriers that discourage the entry into the market of new competitors. Similarly, exclusive contracts restrict the growth of existing anesthesiology groups.

3. The court of appeals correctly defined the relevant geographic market and correctly assessed the Hospital's market power. The district court's market definition was erroneous because it assumed incorrectly that the health care industry functions as a truly competitive market. When the recognized abberational economics of the health care industry are taken into account, it is clear that the Hospital's primary area of competition for the provision of surgical facilities is limited to the East Bank of Jefferson Parish. This conclusion is further supported by the statistical evidence presented at trial and the requirements of Louisiana law. Under a proper market definition, the Hospital unquestionably possessed sufficient power in the market for surgical facilities to restrain appreciably competition in the market for anesthesia services. It was not necessary for Dr. Hyde to show, as the district court had required, that the Hospital "dominated" the tying product market.

4. Both lower courts found that surgical facilities and anesthesia services are separate and distinct products that

could be the subject of a tying arrangement. These findings were supported by substantial evidence, including evidence that surgical facilities and anesthesia services are sold separately by many hospitals (including even the Hospital now that it has "opened" its department of anesthesia), that the two products are priced separately even by those sellers who do tie them together, and that state law requires that hospital services and professional medical services be separate. The several theories offered by the Hospital in support of its argument that surgical facilities and anesthesia services are only one product lack any legal or evidentiary support.

5. The only justification offered by the Hospital for the exclusive contract is that it results in certain "benefits" which permit the Hospital to operate more efficiently and, thereby, to compete better against other hospitals. Under prior decisions of the Court, this purported justification cannot serve to validate the tying arrangement proven by Dr. Hyde. Neither the Hospital nor the courts are in a position to decide that competition in one portion of the economy can be sacrificed in order to promote competition in another portion. This is a decision for Congress.

ARGUMENT

I. *EXCLUSIVE CONTRACTS CAUSE HARM TO PATIENTS.*

It is undisputed that the Hospital's exclusive contract with Roux & Associates deprived patients (either directly or through their surgeons) of the freedom to choose their own anesthesiologist. The evidence also demonstrated that an exclusive contract is likely to be detrimental to the quality of patient care rendered and probably

results in higher costs for patients. Therefore, it is fair to say that exclusive anesthesiology contracts are harmful to patients.

A. *The Contract Deprived Patients and Surgeons of the Freedom of Choice.*

The preservation of freedom of choice in the purchase of goods and services is a basic goal of the antitrust laws. A primary reason why tying arrangements are condemned is that they eliminate this freedom of choice. "One of the evils inherent in any tying arrangement is that it forces the buyer to give up his independent judgment as to whether, or where, to purchase the tied product." *Associated Press v. Taft-Ingalls Corporation*, 340 F.2d 753, 762 (6th Cir.), *cert. denied*, 382 U.S. 820 (1965); citing, *United States v. Loew's, Inc.*, 371 U.S. 38 (1962); *Northern Pacific Railway Company v. United States*, 356 U.S. 1 (1958). See also *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 554 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

Apart from antitrust policy, freedom of choice has always been considered a fundamental right of the patient in the American health care industry. Each of the physicians who testified at trial agreed that a patient should be free to select and be treated by the anesthesiologist of his or her choice. (R., Vol. I, 34-36, 64-65; R., Vol. II, 29, 157-58). A patient's interest in this freedom of choice is easy to understand. "The right to choose involves nothing less dramatic than the right to control what happens to one's body." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 721 (1981).

The Hospital does not dispute that it denied to the patients who used its operating rooms the freedom to choose an anesthesiologist. Instead, it argues that patients do not need this freedom because they would rarely exercise it. According to the Hospital, a patient depends entirely on his or her surgeon to select a hospital and an anesthesiologist. (Brief for the Petitioners, 41-42; R., 49-50).

However, the evidence at trial indicated that some patients do in fact want to have a choice in selecting an anesthesiologist. Dr. Charles Eckert, a member of Roux & Associates, testified that patients sometimes do request a specific anesthesiologist at the Hospital. (R., Vol. I, 87-88). Moreover, the frequency of specific requests by patients is greater with respect to Dr. Hyde's practice, which involves a substantial amount of obstetric work. Obstetric patients develop a closer relationship with their anesthesiologists because they remain conscious throughout the procedure and the anesthetic almost always is administered by an anesthesiologist rather than a nurse. (R., Vol. II, 61-64, 72-74). Therefore, the evidence is that some patients do exercise the freedom of choosing an anesthesiologist when it is permitted.

Even when a patient depends on his or her surgeon to choose an anesthesiologist, the exclusive contract still results in the denial of the freedom of choice. The surgeons who use the operating facilities at a hospital with an exclusive anesthesiology contract have no more freedom to choose an anesthesiologist than the patient. Despite what the patient might believe or the surgeon might desire, it is the hospital, not the surgeon, who chooses the anesthesiologist when one group is given an exclusive contract.

Although it is clear that a hospital takes the freedom

of choice away from patients and surgeons when it enters into an exclusive anesthesiology contract, "[i]t is unclear why a hospital should be allowed to substitute its judgment for the patient's judgment." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 721 (1981). Patients and surgeons may choose an anesthesiologist for personal or commercial reasons that are unrelated to any of the hospital's interests. *Id.* The hospital's judgment, therefore, may not satisfy the needs of the patient.

Nor is the denial of patients' freedom of choice justified by the Hospital's argument that patients (and presumably surgeons) can go elsewhere if they are unhappy with the Hospital's choice of anesthesiologists. (Brief for the Petitioners, 30). Normally, an anesthesiologist is retained only after a patient already has been admitted to, or has been scheduled for surgery at, a particular hospital. As both lower courts recognized, a particular hospital is selected by the patient or surgeon more on the basis of location than any other factor. As long as the anesthesiologist who is available at a particular hospital is competent, a patient or surgeon is unlikely to change hospitals in order to be able to retain another anesthesiologist.

The choice of a surgeon or a hospital is made separately from and in advance of the choice of an anesthesiologist. Thus, even patients and surgeons who otherwise would exercise the freedom to choose an anesthesiologist are likely to allow a chosen hospital to dictate that choice. The fact that patients and surgeons *can* go to other hospitals is not the point. The crucial question is whether patients and surgeons actually *do* change hospitals in order to have a broader choice among anesthesiologists. The realities of the market place indicate that they do not.

The freedom of choice is an important goal, not only for antitrust law but also for the American health care system. Any arrangement that eliminates the freedom of choice should bear a heavy burden of justification.

B. *The Contract Is Detrimental to the Quality of Patient Care.*

The court of appeals set aside as clearly erroneous the district court's finding "that strictly quality considerations led the hospital to enter into an exclusive contract." 686 F.2d at 291 n. 7. The court of appeals was correct. The evidence demonstrated that exclusive contracts actually are detrimental to the quality of patient care for two reasons. First, they result in the replacement of M.D. anesthesiologists with less qualified nurse anesthetists. Second, they eliminate any incentive on the part of the contract group for medical improvement or innovation.

Nurse anesthetists, by themselves, are not detrimental to patient care.[20] To the contrary, in areas where there is a shortage of anesthesiologists they are necessary to the provision of anesthesia services. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45). However, nurse anesthetists are not physicians and they are not licensed to practice medicine. They are authorized to administer anesthetics only under the supervision of a licensed physician. Any arrangements that encourages a greater use of nurse anesthetists to the exclusion of anesthesiologists must be detrimental to

[20] The court of appeals disclaimed any intention "to denigrate the competence of nurse anesthetists." 686 F.2d 291 n. 8. We likewise disclaim any similar intention; nor do we contend that it is improper for nurse anesthetists to administer anesthetics under the medical direction of an anesthesiologist or other qualified physician.

patient care in the long run.[21]

When the exclusive contract between the Hospital and Roux & Associates was in effect, both parties had an economic incentive to utilize as many nurse anesthetists and as few M.D. anesthesiologists as possible. A patient paid the same price regardless whether the anesthetic was administered by a member of Roux & Associates or by a nurse anesthetist employed by the Hospital. Moreover, the patient would pay the same price regardless whether a member of Roux & Associates appeared in the operating room or was even present in the Hospital.[22] Inasmuch as the cost of employing a nurse anesthetist is only a fraction of the cost of employing an M.D. anesthesiologist, a simple profit motive would dictate as many nurse anesthetists and as few M.D. anesthesiologists as possible be employed. Under the exclusive contract, both the Hospital and Roux & Associates would benefit from this form of profit maximization because they shared the proceeds generated by the department of anesthesia. Therefore, neither of them could be expected to protect the interest of patients, who might prefer to receive the professional coverage they were paying for.

Now that the Hospital has "opened" its department of anesthesia and has ended its partnership with Roux & Associates, it no longer faces a financial conflict of interest

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[21] If this conclusion is incorrect, then there would seem to be no reason to train anesthesiologists. Nurse anesthetists could do just as good a job. However, the undisputed evidence was that nurse anesthetists remain necessary only because there still are not enough anesthesiologists. (R., Vol. II, 44-46).

[22] This practice was criticized by the court of appeals as lacking candor in that the patient normally does not realize "that he will be billed for the services of an anesthesiologist who may have had very little contact with his case." 686 F.2d at 291 (footnote omitted). The district court described the practice as "a ripoff." (R., Vol. II, 38).

concerning the use of nurse anesthetists. The anesthesiologists (including Roux & Associates) now practicing at the Hospital employ nurse anesthetists directly and bill their patients directly. The Hospital no longer employs nurse anesthetists or splits professional fees with Roux & Associates.[23] Thus, the Hospital no longer profits from the practice of charging professional fees for work done by nurse anesthetists. The Hospital now is in a position to concern itself with the quality of anesthesia services being rendered, rather than the profits to be realized from them.

Exclusive anesthesiology contracts also are detrimental to the quality of patient care for another, perhaps more subtle, reason: they tend to reduce the incentive for medical improvement and innovation. Product improvement and innovation are basic goals of competition. The monopolist has little economic incentive to improve his product because it is unlikely that by doing so he will increase his sales. In a competitive market, on the other hand, product improvement and innovation often are necessities for survival. In this respect the market for anesthesia services is no different. Where there is no intrahospital competition among anesthesiologists, there is little incentive for the monopolist group to improve the quality of its care or to try innovative procedures. Where there is competition, however, no group can afford to refuse to use improved and innovative procedures for fear of losing business.[24]

In *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Court stressed the importance of product improvement and innovation derived from competi-

[23] The Hospital does still bill patients for the use of equipment, drugs and supplies.

[24] See testimony of Dr. John Adriani quoted at pages 11 and 12, *supra*.

tion. In describing the adverse effects of the illegal maximum price-fixing agreement the Court said:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.

457 U.S. at 348.

Exclusive contracts in the field of anesthesiology have the same effect. They discourage improvement and innovation by shielding the contract group from competition. Where competition is permitted, innovation and improvement become necessary for survival and the patients benefit. Exclusive contracts, by precluding this beneficial competition, are detrimental to the quality of patient care.

C. *The Contract Must Have Resulted in Higher Costs to Patients.*

The evidence at trial did not establish directly whether the Hospital's exclusive contract with Roux & Associates resulted in higher, lower or unchanged costs to patients.[25] This inconclusiveness should not be surprising in a tying case because one purpose of tying is to disguise the prices being charged for tied products. P. Areeda,

[25] The court of appeals' statement that "it is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services," 686 F.2d at 291, merely reflected the inconclusive nature of the direct evidence; it did not constitute a holding of the court.

Antitrust Analysis 572 (2d ed. 1974).[26] However, a consideration of the economics of the exclusive contract indicates that it must have resulted in higher costs to patients.

First, "[c]onventional economic wisdom predicts that as the supply of practitioners with privileges in a relevant specialty area increases, the price of services will decrease if demand remains constant." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 716 (1981); see also, *Id.* at 732. Even in the imperfect health care market, the rules of supply and demand must have some effect. Exclusive contracts unquestionably limit the supply of anesthesiologists available to serve patients and must hereby tend to increase the price of anesthesia services to some extent.

Second, the fact that the exclusive contract required Roux & Associates to share its fees (and profits) with the Hospital indicates that the fees were higher than they otherwise would have been. The fifty percent share of anesthesia proceeds retained by the Hospital under the exclusive contract was a negotiated figure that was unrelated to the Hospital's actual costs (R., 85-86). Because its share of the proceeds significantly exceeded its actual costs, the Hospital derived a substantial profit under the contract. (A., 51). In the absence of the exclusive contract, this profit realized by the Hospital would have been retained by Roux & Associates.

Roux & Associates is a profit-motivated entity and it is reasonable to assume that it would not have agreed to

[26] Thus, even though the Hospital imposed separate charges for use of its surgical facilities and the provision of anesthesia services, the charges may not have reflected a true allocation of the Hospital's costs.

work under a contract which had the effect of lowering the income it otherwise would have realized. However, under its contract, Roux & Associates had to share at least some of its profit with the Hospital.[27] The only way in which Roux & Associates could have shared its profit with the Hospital and yet still have realized the same level of income that it otherwise would have earned was to increase the level of profits by raising the prices charged to patients. Thus, although there was no evidence directly showing that Roux & Associates raised its prices, common sense indicates that it must have done so. At the very least, the fee sharing arrangement in the exclusive contract created an inducement for Roux & Associates to raise its prices.

The exclusive contract gave the Hospital the power to exercise some control over the prices charged by Roux & Associates. (A., 26). However, for unexplained reasons, the Hospital choose not to exercise this power. Instead, the Hospital allowed Roux & Associates to set the fees. (R., 84). Thus, the exclusive contract provided an inducement for Roux & Associates to raise its prices without also providing any effective countervailing control.

Although neither lower court made a finding concerning the effect of the exclusive contract on prices, a common sense analysis indicates that the contract must have resulted in higher prices. At the very least, the contract had the effect of maintaining prices at a level higher than they otherwise would have been.

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[27] To the extent that the Hospital's share of the fees exceeded its costs, it represented profit which would have been retained by Roux & Associates in the absence of a contract.

II. *EXCLUSIVE CONTRACTS SUBSTANTIALLY ELIMINATE COMPETITION AMONG ANESTHESIOLOGISTS.*

Exclusive contracts substantially eliminate competition among anesthesiologists both directly and indirectly. Competition is restrained directly by the denial to all but the contract group of something that each anesthesiologist must have in order to compete for business in any hospital: staff privileges. Indirectly, exclusive contracts restrain competition by discouraging new anesthesiologists from entering the market and restricting the growth of existing anesthesia groups.

Normally, an anesthesiologist is selected by a surgeon, rather than a patient, on the basis of an existing working relationship. (R., Vol. II, 26-27). In order for a surgeon and an anesthesiologist to develop a working relationship, they must have the opportunity to work together on a regular basis. (R., Vol. II, 27). By denying Dr. Hyde admission to the medical staff, the Hospital also denied him the opportunity to develop a working relationship with the surgeons who utilize the Hospital's surgical facilities. If the surgeons who work at the Hospital are compelled to use only the anesthesiologists employed by Roux & Associates on a regular basis, then those are the only anesthesiologists with whom they will become familiar and, therefore, the only anesthesiologists that they will use.[28]

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[28] Moreover, the nature of Dr. Hyde's practice makes it much more likely that patients as well as surgeons will request his services. See discussion at page 22, *supra*. Thus, Dr. Hyde's exclusion from the Hospital's medical staff prevented his selection by patients as well as by surgeons.

The fact that Dr. Hyde had staff privileges at another hospital did not necessarily cure the harm. First, the denial of medical staff privileges "is a competitive disadvantage, if for no other reason than it connotes a second-class practitioner." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 714 (1981). This is particularly true at a community hospital perceived by patients to be "public" in the sense of being open to all qualified physicians. Second, the evidence showed that staff membership at the Hospital, because it is a large, public facility, offers greater professional opportunities to anesthesiologists than does staff membership at a smaller facility. For example, at Lakeside Hospital, where Dr. Hyde primarily practiced, approximately fifty percent of the cases are obstetric (R., Vol. II, 62). An anesthesiologist at Lakeside does not have the opportunity to do the more complicated cases and to use the more sophisticated equipment available at a large facility like the Hospital. (R., Vol. I, 90-91).

In *Associated Press v. United States*, 326 U.S. 1 (1945), the Court held that a wire service's restrictive bylaws violated the Sherman Act by restraining competition among newspapers. In response to the argument that the wire service did not have to sell news to all newspapers because there were other news agencies which provided similar services, the Court stated:

> But the fact that an agreement to restrain trade does not inhibit competition in all of the objects of that trade cannot save it from the condemnation of the Sherman Act. It is apparent that the exclusive right to publish news in a given field, furnished by AP and all of its members gives many newspapers a competitive advantage over their rivals. Conversely, a newspaper without AP

> service is more than likely to be at a competitive disadvantage.

326 U.S. at 17-18 (footnotes omitted).

Just as a newspaper can survive without the Associated Press, so can an anesthesiologist practicing in Jefferson Parish, Louisiana survive without staff membership at the Hospital. After all, there are other hospitals at which to practice.[29] However, that is not the test according to *Associated Press v. United States.* By virtue of the Hospital's size, public nature and reputation as a quality facility, the physicians to whom it grants staff privileges are given a competitive advantage over those to whom it does not. The result is particularly objectionable where, as here, the competitive advantage is based not on the relative skill and competence of the competitors, but rather on a contract.

In addition to the direct anticompetitive effects, exclusive contracts also restrain competition among anesthesiologists indirectly by restricting practice opportunities and thereby discouraging the entry of additional anesthesiologists into the market. Although there is a shortage of anesthesiologists in the area, locally trained anesthesiologists actually are forced to go elsewhere to practice because of the lack of local openings. (R., Vol. II, 30-31). For the same reason, anesthesiologists from other areas are discouraged from entering the market (R., Vol. II, 92-95). As a practical matter, an anesthesiologist must find employment with an existing group if he or she is to work at all.

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[29] In fact, of all the hospitals in Jefferson *and* Orleans Parishes, only three had "open" anesthesiology departments at the time of trial. (R., Vol. II, 47-49). Therefore, those three hospitals would have to support all of the anesthesiologists who were not fortunate enough to have exclusive contracts at the others.

However, even the existing groups are restricted in the employment of new members because they are prevented from expanding their practices into hospitals that maintain exclusive contracts with other groups.[30]

In essence, the Hospital's exclusive contract with Roux & Associates created a monopoly that protected both Roux & Associates and the Hospital from competition.[31] Where, as here, most of the hospitals in the area utilize exclusive contracts, the result is a shared monopoly, with each hospital and contract anesthesiology group being allocated a portion of the market. See Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 760 (1981); Kissam, Webber, Bigus and Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 664 (1982). This division of the market does not merely restrict, but substantially eliminates competition among anesthesiologists. See *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972).

The Hospital argues that the foreclosure of competition on a local level is unimportant because anesthesiologists "compete" for exclusive contracts on a national basis. (Brief for the Petitioners, 36-39). This argument lacks merit for several reasons. First, it conveniently ignores the fact that anesthesiologists are mobile primarily because local anticompetitive conditions force them to be. Anesthesiologists often are unable to find positions in areas in which

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[30] For example, Dr. Hyde described at trial how the inability of his group to practice at the Hospital made it more difficult to recruit new group members. (R., Vol. II, 79-80).

[31] The two members of the Hospital Board who testified at trial agreed that the exclusive contract created a monopoly for Roux & Associates. (R. Vol. II, 158-59, 195).

the use of exclusive contracts are prevalent. Therefore, they must be mobile in order to work. It is easy to minimize the significance of a competitive restraint in a local market simply by increasing the size of the market until the restraint becomes "immaterial in this larger perspective." (Brief for the Petitioners, 37). This academic exercise, however, does not reduce the impact of the restraint on local competition.

Second, the Hospital's argument is based on the false premise that anesthesiologists sell their services to hospitals rather than patients. Hospitals neither receive anesthesia nor pay for it. Patients do. It is true that, in the absence of exclusive contracts, anesthesiologists normally are selected by surgeons. It also is true that hospitals, by utilizing exclusive contracts, take the selection of an anesthesiologist out of the hands of the surgeon. However, the patient is always the purchaser and the consumer of the anesthesia. Roux & Associates no longer has any contractual relationship with the Hospital and it bills patients directly for anesthesia services. Surely the Hospital would not claim that it now purchases anesthesia services from Roux & Associates.

A third flaw in the Hospital's argument is that it assumes, incorrectly, that anesthesiologists actively compete for exclusive contracts. The evidence is to the contrary. The Hospital selected Dr. Roux before it opened its doors in 1971 and it has not required Roux & Associates to compete with any other group since then. The only competition has been between Roux & Associates and the Board over whether Roux & Associates would be allowed to practice at the Hospital without a contract.[32] When the Hospital attempted

[32] The Hospital's assertion that the 1976 contract was preceded by "a second round of bids in 1976" (Brief for the Petitioners, 39) has no evidentiary basis.

to negotiate with Dr. Roux in 1975 to renew the 1971 contract, Dr. Roux initially refused to negotiate and took the position that his group would employ nurse anesthetists and bill patients directly. (R., Vol. II, 134, 158-59). Dr. Roux finally signed the 1976 contract only after the Hospital threatened to contract with another group, which would mean that Roux & Associates could no longer practice at the Hospital. (R., Vol. II, 160-63). Thus, as the court of appeals observed, "the hospital, in fact, has not permitted this competition [for the exlusive contract] since the original contract was signed over ten years ago." 686 F.2d at 291-92 n. 9.

Moreover, even if there were limited competition among anesthesiologists to obtain exclusive contracts, overall competition still would be severely restrained. If each of the thirteen judges of the United States District Court for the Eastern District of Louisiana chose two law firms and required each litigant to employ one of the two firms, competition among lawyers obviously would be restrained. Instead of having the freedom to choose among the thousands of lawyers licensed in the district, a litigant would be required to choose from among only those lawyers employed by the twenty-six law firms chosen by the district judges. Arguably, the judges are in a better position than an individual litigant to evaluate and bargain with the law firms chosen and the system undoubtedly would simplify court administration. Furthermore, assuming that it were permitted, law firms would be likely to compete with one another to be selected by the judges. However, it could not be said that this arrangement would not severely restrain competition among lawyers. Among the thousands of lawyers who otherwise would be available to represent litigants, the entire market would be allocated to those employed by the twenty-six chosen law firms.

The competitive impact of the use of exclusive contracts in the field of anesthesiology is no different. Exclusive contracts restrain competition among anesthesiologists by limiting artificially the choices available to patients and surgeons. Therefore, the exclusive contract is illegal.

III. *THE COURT OF APPEALS' DETERMINATIONS REGARDING THE RELEVANT GEOGRAPHIC MARKET AND THE HOSPITAL'S MARKET POWER WERE CORRECT.*

A. *The East Bank of Jefferson Parish Is the Relevant Geographic Market.*

The district court defined the relevant geographic market to include at least the East Bank of both Jefferson and Orleans Parishes. 513 F.Supp. at 540. The court of appeals held that the district court's market definition was erroneous because it assumed incorrectly that the health care industry functioned as "a truly competitive market." 686 F.2d at 290. The court of appeals recognized that, given the market imperfections inherent in the health care industry, the geographic market in which the Hospital primarily competes actually is limited to the East Bank of Jefferson Parish.

The abberational economics of the health care industry has been widely recognized. See, *e.g.*, M. Thompson, *Antitrust and the Health Care Provider* (1979) 33-36; Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 738-39 (1981); Shapiro, *Cost Containment in the Health Care Field and the Antitrust Laws*, 7 Am. J. of Law and Medicine 425, 428-29 (1982); Note, *Antitrust and Nonprofit Entities*, 94

Harv. L. Rev. 802, 803-05 (1981). In general, the commentators agree that the health care industry is a closed market characterized by heavy government regulation, a lack of information on the part of patients regarding quality and prevalent third party payment of medical fees. Patients realistically cannot compare the quality of hospital services offered at different hospitals and, due to third party payment of fees, they have no incentive to compare cost. Therefore, patients tend to favor public, nonprofit facilities[33] close to their homes. Similarly, surgeons are likely to favor hospitals close to their offices.

The district court in fact recognized the preference of patients for hospitals near their homes. It stated:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible.

513 F.Supp. at 543. In other words, the district court found that, all other things being equal, a resident of the East Bank of Jefferson Parish probably will prefer to be admitted to a hospital in that area over all other hospitals in other surrounding areas. However, the district court inexplicably failed to take this finding into account in defining the relevant geographic market. As the court of appeals was unable to reconcile the district court's findings, it held that the court's market definition was erroneous. 686 F.2d at 290-91.

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[33] Public, nonprofit entities are likely to be favored because they have no apparent profit motive to cut quality. Note, *Antitrust and Nonprofit Entities*, 94 Harv. L. Rev. 802, 803-04 (1981).

The conclusion that the Hospital's area of effective competition is limited to the East Bank of Jefferson Parish also was supported by the statistical evidence presented at trial. That evidence showed that over seventy percent of all persons admitted to the Hospital during the study period resided on the East Bank of Jefferson Parish. (A., 50). Furthermore, approximately thirty percent of all hospital admissions of East Bank Jefferson Parish residents were to the Hospital. These figures indicate that the Hospital competes primarily only on the East Bank of Jefferson Parish.

The court of appeals found further support for its geographic market definition in the statutory limitation placed on the District and the Board by state law. The statutory purpose of the District is to own and operate hospitals within the District and to provide hospital and other health services to the residents of the District. La. R.S. 46:1052. As the geographic boundaries of the District encompass only that part of Jefferson Parish located on the East Bank of the Mississippi River (Pl. Ex. 1; R., 7, 94), that is the area in which the District is directed by the statute to perform its purpose. Similarly, the Board is directed by La. R.S. 46:1055 "[t]o represent the public interest in providing hospital and medical care *in the district.*" (emphasis supplied). Thus, by law, the Hospital's primary purpose is to serve the residents of the East Bank of Jefferson Parish. Although the Hospital may, by necessity or by choice, also accept residents of other areas, its primary market area is limited by law to the East Bank of Jefferson Parish.

Taken as a whole, the evidence showed that the Hospital's primary area of competition is the East Bank of Jefferson Parish. Accordingly, the court of appeals was correct in holding that the district court's broader market definition was erroneous.

B. *The Hospital Has Sufficient Market Power to Establish a Per Se Violation.*

The evidence demonstrated that the Hospital captures almost thirty percent of all patients residing in the relevant geographic market. Based upon this evidence, the court of appeals held that the Hospital's power in the market for the tying product was sufficient to satisfy the test for per se illegality. The court of appeals unquestionably was correct.

The decisions of this Court have never required a showing of monopoly, or even dominant, market power in the tying product in order to establish a per se illegal tying arrangement. In *International Salt Company v. United States*, 332 U.S. 392 (1947), the Court affirmed a summary judgment holding illegal leases of salt dispensing machines that required the lessee to use the machine only with salt purchased from the lessor. The only evidence of the lessor's market power was that its annual sales of salt amounted to almost $500,000. In affirming, the Court stated that "it is unreasonable, *per se*, to foreclose competitors from any substantial market" and that the lessor's sales volume "cannot be said to be insignificant or insubstantial...." *Id.* at 396.

In *Fortner Enterprises, Inc. v. United States Steel Corporation*, 394 U.S. 495, 503-04 (1969) ("*Fortner I*"), the Court made the following observation concerning the showing of tying product power required:

> [D]ecisions rejecting the need for proof of truly dominant power over the tying product have all been based on a recognition that because tying arrangements generally serve no legitimate

> business purpose that cannot be achieved in some less restrictive way, the presence of any appreciable restraint on competition provides a sufficient reason for invalidating the tie. Such appreciable restraint exists whenever the seller can exert some power over some of the buyers in the market, even if his power is not complete over them...[D]espite the freedom of some or many buyers from the seller's power, other buyers—whether few or many, whether scattered throughout the market or part of some group within the market [could] be forced to accept [a] higher price because of their strong preferences for the product, and the seller could therefore choose instead to force them to accept a tying arrangement that would prevent free competition for their patronage in the market for the tied product.

The Court restated its position concerning the degree of market power required in *United States Steel Corporation v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) ("*Fortner II*"). The Court said:

> As the Court plainly stated in its prior opinion in this case, *these decisions do not require that the defendant have a monopoly or even a dominant position throughout the market for a tying product.* They do, however, focus attention on the question whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market. In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.

Id. at 620-21 (emphasis supplied; citation and footnote omitted).

The Hospital has the competitive "advantage" described in *Fortner II* by virtue of its unique position as the only public hospital on the East Bank of Jefferson Parish. As discussed in Part A, above, the health care industry is characterized by market imperfections that favor public, nonprofit hospitals located near patients and their physicians. Given the inability to compare quality and the lack of incentive to compare cost, patients and surgeons are more likely to choose a public facility which has no apparent profit motive to reduce quality.

The Hospital's ability to attract almost thirty percent of all hospital patients residing on the East Bank of Jefferson Parish is a good indication of the market power that it possesses. The Hospital's role as the only public institution in the market creates a "strong preference" (*Fortner I*) for its surgical facilities and gives it the power "to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market" (*Fortner II*). One burdensome term that patients were required to accept was the Hospital's refusal to allow them to select the anesthesiologist of their choice. In addition, the ability of the Hospital to utilize a tying arrangment gave it the power to raise prices for its surgical facilities by disguising the additional costs as anesthesia fees.

It was not necessary for Dr. Hyde to show, as the district court required, that the Hospital "dominated" the tying product market. The Hospital possesses sufficient power in the market for surgical facilities to restrain competition in the market for anesthesia services. Accordingly, the market power requirement for per se illegality was satisfied.

IV. *SURGICAL FACILITIES AND ANESTHESIA SERVICES ARE SEPARATE AND DISTINCT PRODUCTS.*

Both the district court and the court of appeals found that surgical facilities and anesthesia services are separate and distinct products. These findings are well supported by fact and by law.

First, it is undisputed that surgical facilities and anesthesia services are sold separately by many hospitals.[34] Indeed, now that it has "opened" its department of anesthesia, even the Hospital sells these products separately. The existence of other sellers who do not "package" their products is one indication of product separability. *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 559 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

Second, surgical facilities and anesthesia services are separately priced even by those sellers who do tie them together. Although separate pricing by itself would not establish the existence of two products, it is another factor which tends to show that two products exist. *Id.*

Third, hospitals and physicians are subject to

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[34] It is important to recognize the difference between clinics, such as the Mayo Clinic or the Cleveland Clinic, and acute care general hospitals. Clinics combine in a single business medical services and all ancillary facilities necessary to provide those services from initial consultation to final surgery and convalescence. In the case of a clinic, the patient looks to the institution for medical care and all attendant ancillary services and the institution can be said to compete with other similar institutions. The Hospital is not a clinic. In most instances, patients who are admitted to the hospital go initially to an individual physician or group of physicians.

separate and independent licensing systems which *require* that hospital services and medical services be separate. Under Louisiana law, a hospital legally cannot engage in the practice of medicine. Only the physicians who practice within the hospital are licensed to practice medicine.[35] Therefore, it is the members of Roux & Associates, not the Hospital, who rendered anesthesia services to patients; and the rendering of professional anesthesia services by licensed physicians cannot be characterized as merely a part of "hospital care."

In his complaint, Dr. Hyde alleged that the exclusive contract violated Louisiana law because it called for "fee splitting" between Roux & Associates and the Hospital and the exercise of professional medical discretion by the Hospital. (A., 6-7). In other words, Dr. Hyde alleged what the petitioners argue now: that the Hospital actually was practicing medicine by providing professional anesthesia services to patients. The district court, however, disagreed. It stated:

> The Court finds that the hospital did not improperly engage in the diagnosis and treatment of patients. *The evidence shows that the anesthesia services are provided by the anesthesiologist who prescribes the drugs used and performs all procedures requiring expertise.* The CRNA's work under the supervision of the anesthesiologists and their function is to monitor the patients while they are anesthetized.

[35] The petitioners' attempt to analogize the Hospital to a law firm (Brief for the Petitioners, 40 n. 24) misses the point. The individual lawyers in a law firm either own or are employed by the firm. Thus, the firm can act only through them. The Hospital neither was owned by nor did it employ Roux & Associates. Roux & Associates is a professional corporation which itself employs the individual anesthesiologists. Therefore, a better analogy could be drawn between a law firm and a professional corporation of anesthesiologists.

513 F.Supp. at 540 (emphasis supplied).

Thus, the district court found that the provision of anesthesia services is not merely a part of a total "package" of hospital services. Rather, it is a professional service rendered by licensed anesthesiologists who are legally responsible for the anesthesia care received by the patients. As the district court observed, the Hospital furnishes only materials and nonprofessional services "in connection with" the work of the anesthesiologists.

In the face of the contrary findings of both lower courts, the Hospital argues in this Court that surgical facilities and anesthesia services really are only one product.[36] In support of this argument the Hospital offers several different theories.

First, it is asserted that surgical facilities and anesthesia services are one product "because it is often more economical to supply them together than to supply them separately." (Brief for the Petitioners, 39). Economical for whom? Certainly not the patient. The economics of the challenged exclusive contract indicate that, in all probability, it resulted in higher prices for patients. At the very least, the contract created an inducement for Roux & Associates to raise its prices in order to recoup the profits that it distributed to the Hospital. Furthermore, the Hospital declined to exercise any control over the prices set by Roux & Associates. Any assertion that the Hospital's patients received some economic

[36] We do not contend, as the petitioners suggest (Brief for the Petitioners, 39 n. 23), that this issue was not preserved in the court of appeals. We merely point out that this issue was not raised by the Hospital in the lower courts.

benefit simply has no evidentiary basis.[37]

The second theory offered by the Hospital in support of its one-product argument is that two products cannot be the subject of a tie unless each is "independently useful" and cannot be "conveniently used as a unit." (Brief for the Petitioners, 40). This cannot be the test. Computers and punch cards had no independent usefulness and were conveniently used together; yet they were held to be the subjects of an illegal tying arrangement in *International Business Machines Corporation v. United States*, 298 U.S. 131 (1936). Salt and salt dispensers could be "conveniently used as a unit," yet they were considered to be separate products for tying purposes in *International Salt Company v. United States*, 332 U.S. 392 (1947). Similarly, in *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961), the components of a television antenna system were held to be separate products. Independent usefulness may be one factor to consider in determining product separability. It is not, as the Hospital suggests, the sole criterion.

Finally, the Hospital asserts that "[t]he only useful approach is to ask whether the particular aggregation threatens competition on the merits." (Brief for the Petitioners, 42). This is not much different than the require-

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[37] If the Hospital means to say that the exclusive contract is "economical" in the sense that it was needed in 1971 in order to attract an anesthesiologist to the Hospital (see testimony of Dr. John C. Rourke and Nickolas Gagliano quoted at pages 5-6, *supra*), that situation is no longer the case. (R., Vol. II, 196-97). Where a defendant seeks to justify a tying arrangement on grounds of economic necessity, he has "the burden not only of establishing the initial existence of the facts necessary to support [his] claim but also their continuing existence in view of the fact that it is not disputed that the conditions did change." *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 560 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

ment of *Northern Pacific Railway Company v. United States*, 356 U.S. 1, 6 (1958), that the defendant be shown to have "sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product." As discussed in Section II of this Argument, the exclusive contract unquestionably does restrain competition in the market for anesthesia services. It directly denies to all but the contract group what any anesthesiologist must have in order to compete—staff privileges. Moreover, it indirectly impairs competition by creating serious entry barriers for new anesthesiologists. If the effect on competition is the test, then surgical facilities and anesthesia services clearly are separate and distinct products.

The findings of the lower courts that surgical facilities and anesthesia services are separate products are supported by the evidence and the law. The arguments of the Hospital against those findings are unsupported and should be rejected by the Court.

V. *THE PURPORTED JUSTIFICATIONS OFFERED BY THE HOSPITAL FOR THE EXCLUSIVE CONTRACT CANNOT VALIDATE THE TYING ARRANGEMENT THAT THE CONTRACT CREATED.*

Once a per se rule is found applicable, economic or competitive justifications for a restraint of trade become irrelevant. Therefore, the purported justifications offered by the Hospital for the exclusive contract legally cannot validate the tying arrangement created by the contract.

In the lower courts, the Hospital identified several purported benefits that it contended were derived from the

"closed" staff system utilized in the department of anesthesiology. These purported benefits included the assurance of twenty-four hour a day anesthesia coverage, easier monitoring of specialized equipment and supervision of nurse anesthetists, greater flexibility in scheduling the use of operating rooms, and allowing anesthesiologists and nurse anesthetists to form a closer working relationship. See 686 F.2d at 288; 513 F.Supp. at 540. The Hospital contends that these benefits allow it to operate more efficiently and thereby help it compete against other hospitals.

The court of appeals found that these "benefits" either were not shown by the record to exist or obviously could be achieved by less restrictive means. 686 F.2d at 292. More importantly, the court of appeals rejected in principle the Hospital's argument that the tying arrangement created by the exclusive contract could be justified by these asserted procompetitive benefits. *Id.* at 294. The court of appeals' ruling on this issue was consistent with the decisions of this Court, and therefore, it should be upheld.

In *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972), the Court held that an exclusive territorial licensing system for private label supermarket brands was illegal per se because it eliminated intrabrand competition at the retail level. In defense of the system, the cooperative association which owned the private label brands argued that the restriction of intrabrand competition actually was procompetitive in that it helped the association's "members to compete successfully with larger regional and national chains." *Id.* at 606. The Court flatly rejected this argument, stating:

> in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion and ingenuity whatever economic muscle it can muster. *Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy.*

405 U.S. at 610 (emphasis supplied).[38] The Court concluded that "[i]f a decision is to be made to sacrifice competition in one portion of the economy for greater competition in another portion this too is a decision that must be made by Congress and not by private forces or by the courts." *Id.* at 611. See also *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

More recently, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Court again flatly rejected the argument that procompetitive justifications could save what otherwise was a per se illegal restraint. The court said:

> The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price fixing agreements justifies

[38] The Court also pointed out that "[o]ur inability to weigh, in any meaningful sense, destruction of competition in one sector of the economy against promotion of competition in another sector is one important reason we have formulated *per se* rules." 405 U.S. at 609-10.

> their facial invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application.

457 U.S. at 351 (footnote omitted).

Maricopa and *Topco* are controlling here. Dr. Hyde proved the existence of a per se illegal tying arrangement. The Hospital's only real defense is that the exclusive contract which created the tying arrangement is justified because it makes the Hospital more efficient and thereby helps it compete against other hospitals. This argument was foreclosed by *Topco* and *Maricopa*.

CONCLUSION

The Hospital's exclusive contract with Roux & Associates created a per se illegal tying arrangement. The decision of the court of appeals was correct and it should be affirmed.

Respectfully submitted,

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